



Table of Contents

- 3** **Everyday stories . . . profiles of your CAOT colleagues**
Kate Walsh
- 4** **What's new**
- 4** **What's online**
- 5** **Remote Canadian occupational therapy: An "outside the box" experience**
Janna MacLachlan
- 8** **Meaningful participation: CAOT's consultation for the Convention on the Rights of Persons with Disabilities**
Janet Jull, CAOT Policy Analyst
- 11** **The use of lighting to prevent falls: Some preliminary evidence**
Dorothy Kessler, Frank Knoefel and Rafik Goubran
- 14** **PRI VATE PRACTICE INSIGHTS**
Occupational therapists as Clinical Care Managers with Veterans Affairs Canada
Marion Hutton
- 15** **The Canadian Falls Prevention Curriculum: An on-line interdisciplinary learning opportunity**
Mary Lou Boudreau
- 16** **THEORY MEETS PRACTICE**
Inclusive environments: The role of occupational therapy
Katie Semple, Beth Blowes, Elizabeth Steggles and Sue Baptiste
- 19** **E-HEALTH AND OCCUPATIONAL THERAPY**
To be or not to be on Facebook: That is the question
Rashid Kashani, Susan Burwash and Anita Hamilton
- 23** **Enabling Occupation II updates 2010**
Janet Craik, CAOT Director of Professional Practice
- 26** **Building workforce capacity for occupational therapy in Canada**
Claudia von Zweck, CAOT Executive Director
- 30** **Update from the COTF**
- 31** **CAOT endorsed courses**

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In Memoriam: Gary Kielhofner



It is with deep sadness that we communicate to you the passing of our beloved colleague, mentor, and friend Dr. Gary Kielhofner. Gary Kielhofner was a remarkable man, a visionary, a passionate scholar. As a beginning scholar, over 30 years ago, he had a dream of advancing the field of occupational therapy in order to assist individuals with chronic health conditions and disability live fulfilling and satisfying lives. His dream became a reality when he crafted the Model of Human Occupation, also known as MOHO.

Gary's work has inspired and impacted the lives of thousands and thousands of therapists, students, clients and colleagues. He made history, broke ground, and shaped the future of the profession. He shared a unique sense of pride when mentoring students and colleagues, bringing out the best in them. Gary's accomplishments are too many to enumerate. His work will continue and persevere for generations to come, as he changed the way we think and conduct research, the way we conceive occupation and the way we help clients live fulfilling lives.

Yolanda Suarez-Balcazar

Professor and Head,

Department of Occupational Therapy, University of Illinois at Chicago

Everyday stories . . . profiles of your CAOT colleagues



Kate Walsh

Education

Bachelor of Applied Science in Occupational Therapy at Sydney University in Sydney, Australia (1992-1996).

Career path as an occupational therapist

It's been a colourful twelve years. Three countries of practice, four if I include my three month university placement in India with Community Based Rehab in the poorest state in the country, Orissa. My occupational therapy career has been the portal to the wonderment of acute psychiatry in London, England, where clients lives resembled characters out of an amazing fiction novel; to the demanding drive of occupational rehabilitation and the medico-legal realm in private practice in Australia; to the gentler but complex practice of community based rehabilitation in Vancouver, BC.

As my experience as an occupational therapist unfolds, I have discovered and continue to appreciate the complexity in this profession. Occupational therapy has allowed me to explore all facets of my personality. I am humbled by the people that I work with, the client's lives that I become a part of, and the work required of me.

My path has taken me in different directions over the years and I have constantly challenged myself. There have been times when I have been naïve or perhaps chosen to ignore healthcare skepticism when stepping up into roles historically held by other professions. The way I have seen it, occupational therapists can break through glass ceilings when they wish to move beyond frontline positions. With the support of forward thinking managers, I have taken on Intake roles, Clinical Coordinator roles and Complex Discharge Planning positions from acute to community environments. I believe strongly in the assessment and resource skills unique to my occupational therapy perspective and provision of recommendations to meet client and family needs. There were many times when I heard "it's great to have an occupational therapist on board."

Apparently, there are ten defining moments in one's life. I experienced one of these moments at the age of 33. I needed to make a choice to study medicine or building/architecture. I made a choice, and six months of personal time off completing the British Columbia Institute of Technology (BCIT) Carpentry Framing and Formwork Level 1 -2 clarified the moment. I continued with an Architectural Building and Technology program at night

and volunteered with Habitat for Humanity solidifying my hands on skills. I blame my dad, I tell my mum. Being a Civil Engineer he would teach his three little girls about the beams and trusses of a Church whilst mum thought we were just praying to the heavens.

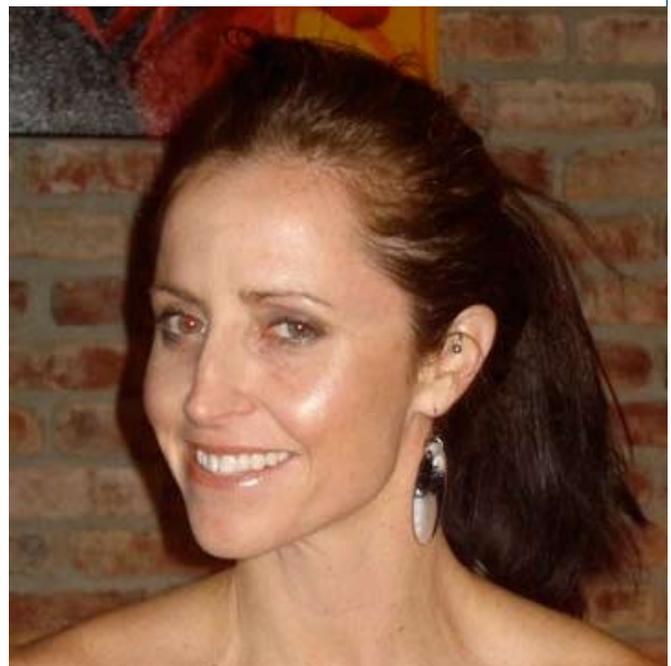
My main drive to pursue building and architecture skills actually came from the frustrations of working with clients and contractors for home modifications or retrofit buildings, and more-so lately the deemed 'universally' designed facilities, assisted living buildings, independent living senior centres. The theoretical aspect of building and designs I can now appreciate but like life, it needs work. And I want in at the blueprint level!

Family life

I have a wonderful family both here in Canada and back in Australia, who I will be joining next year with my beautiful partner, Amy – another great gift in life! Our gorgeous and handsome dog Jack, a furry malamute dressed in golden retriever clothing, ensures we keep real every day. His profile picture is better than mine. I hope that one-day Australia will offer us the freedoms inherent in Canada, so we too can extend our family.

Hobbies/interests

I love to snowboard, travel and eat my way around the world, building buildings and architecture!





What's new

New federal funding of almost \$1 million for six elder abuse initiative projects was announced by the Honourable Diane Ablonczy, Minister of State (Seniors) at the World Elder Abuse Awareness Day conference in Toronto on June 15, 2010. The funded projects include a \$141,000 initiative of CAOT to develop and disseminate a guideline document and web-based tutorial to educate members on indicators of elder abuse, prevention, intervention and reporting protocols, relevant legislation, and available resources for older adults. The goal of these resources is to provide members with increased awareness and understanding of elder abuse, and to enhance their capacity to respond to situations of abuse. Pictured are Claudia von Zweck, CAOT Executive Director, Minister of State (Seniors) Diane Ablonczy, and Laura Meyers, Director of Education of the Canadian Dental Hygienists Association.



What's online

CAOT Position statements

These quick reference sheets will help you to understand CAOT's position on issues that affect occupational therapists and their clients. Visit 'Professional Practice' on www.caot.ca for a full listing.

New and updated position statement for 2010 include:

1. Quality and Occupational Therapy Services
2. Obesity & Healthy Occupation
3. Feeding, Eating and Swallowing

hOT Topics

hOT Topic resource sheets are coordinated by CAOT and are geared to provide occupational therapists and occupational therapy students with a list of references (journals, books, assessments, and additional information) in areas identified as emerging and/or topical by members. CAOT invites you to contribute to the ongoing development of these documents. Visit 'Periodicals and Publications' on www.caot.ca for the full lists.

Current posted hOT topic resource lists include:

Cultural Competence	Dysphagia
Leadership	Occupational Community Development
Obesity	

Coming soon:

Universal Design	Low Vision
Driving	Enabling Occupation through Orthotic Intervention

Remote Canadian occupational therapy: An “outside the box” experience

Janna MacLachlan



Articles by occupational therapists and occupational therapy students doing international work describe unique practice environments and how “thinking outside the box” must be used with limited resources to accomplish goals. Occupational therapists who work in remote regions of Canada know that practice can be as “outside the box” and unique as it is in many international countries. An example is this quote from one Canadian occupational therapy job description: “travel within the communities may be by foot, snowmobile, ATV or vehicle in adverse weather conditions”. That job description is mine and I work in Nunavut. True to the job description, I have found myself on the back of an ATV with a tub transfer bench under my arm.

On a daily basis I work with Nunavummiut (residents of Nunavut) to enable occupation. The majority of my clients are Inuit and there are many culturally-specific occupational performance issues to be addressed. Examples include working with someone with dysphagia so they can eat country foods (Inuit traditional foods, including bannock, berries, raw, frozen or cooked meats such as seal, muktuk [whale blubber and skin], and caribou) or working with a woman who has rheumatoid arthritis and is having difficulty skinning seals. These are unique issues requiring “out of the box” thinking. The purpose of this article is to draw attention to the remote regions of Canada and encourage discussion about how occupational therapy services are provided in these areas. A case study demonstrating the remote context, some common barriers, and how the barriers can be overcome will be presented.

Case study: Mr. Simeonie

Mr. Simeonie (a pseudonym) was a 69-year old Inuk gentleman living in Pangnirtung, Nunavut with end-stage COPD. He no longer had the strength to propel his manual wheelchair even a few meters around his home and wanted a power wheelchair.

Context

Baffin Region occupational therapists reside in Iqaluit, a one-hour flight South of Pangnirtung, Mr. Simeonie’s home community. There are no roads connecting any communities in Nunavut. With a guide, snowmobile and survival gear, one could get there in approximately twelve hours over the tundra, but as of yet, we have not taken that route for work trips. Currently, resources permit one occupational therapy visit per year to each of

the eleven communities outside of Iqaluit in the Baffin region.

Assessment

I received the request for a power wheelchair in March but would not be visiting Pangnirtung until August. The trip would last for one work week and I would be attempting to see more than thirty clients in a clinic, their homes or in a school. It is important to complete as much client preparation as possible in advance. Luckily every health centre in the Baffin Region is connected to telehealth. An assessment for a power wheelchair can begin via telehealth, where the occupational therapist can gather general information of the client’s physiology.

The telehealth session was not required for Mr. Simeonie as I already knew him quite well and knew much of his information. I also received frequent updates from his home care nurse and daughter. I agreed it would be appropriate to pursue power mobility.

Funding

Non-Insured Health Benefits (NIHB) is a Federal program that pays for essential medical supplies and equipment for First Nations and Inuit across Canada. Funding was not a barrier for Mr. Simeonie as his medical condition qualified him for power mobility under this program.

Equipment provision

The occupational therapists in the Baffin Region of Nunavut provide a wide-range of services to the population of 15 000 people. With only a handful of individuals requiring power mobility across this vast region (roughly the size of the province of Ontario), vendors and trial chairs are not available. Typically, anyone in Nunavut requiring power mobility flies to Ottawa for assessment and prescription. Mr. Simeonie’s medical condition was fragile and it was not recommended for him to make the four hour flight from his community that is 50 km South of the Arctic Circle.

Fortunately there were others who used power wheelchairs living in Mr. Simeonie’s community of about 1300 people. Prior to my trip, I phoned one of these individuals and asked if he would mind if I borrowed his power wheelchair for a morning to trial with “another individual”. The client’s name was not revealed, but not surprisingly when I borrowed the chair, the lender asked me to ‘say hello to Mr. Simeonie’. I drove this generously-loaned power wheelchair to Mr. Simeonie’s

house across unpaved roads, which in August are rocky, and riddled with potholes. In winter, they would be covered with packed snow and ice (see Figure 1). There are no alternatives to these driving conditions as there are no wheelchair-accessible buses, vans or taxis in the community.

With the loaned power wheelchair I was able to assess the fit of the chair and determine Mr. Simeonie's requirements. I was also able to assess his ability to drive the chair.

Once I had a sense of Mr. Simeonie's needs and abilities, I applied for funding and ordered a power



Figure 1. Mr. Simeonie navigates snow and ice covered roads in Pangnirtung.

wheelchair. I tried not to worry that the chair would not fit, or how I would cover the multi-hundred dollar shipping cost to return it if it was not correct. Not to mention the extra months (not weeks or days) that this would delay Mr. Simeonie in receiving the equipment he needed. After three months of working out details with the vendor, getting NIHB funding approval and waiting for shipping, the chair arrived. The next step was fitting the power wheelchair for Mr. Simeonie.

Flights to Baffin Region communities from Iqaluit range in price between \$300 and \$3000 and the rehabilitation budget can not fund these each time there is a wheelchair to fit. I sometimes fit (and measure for) manual wheelchairs via telehealth for individuals with very basic seating needs. I instruct a nurse in how to adjust foot-rests, arm-rests, and so on. I also provide education about maintenance, safety and use. This use of telehealth is justified as the benefits of getting someone a wheelchair to reduce a fall risk and enable participation in occupation outweigh the potential harm.

A power wheelchair, however, is not basic seating, and my manager was able to dig up funding for me

to travel to Pangnirtung for the fitting. I arrived to find Mr. Simeonie had had an exacerbation of his illness and was unable to attend the fitting. I hoped that he would be better by the next day. We travel to communities prepared for flexible scheduling. We could arrive to discover that caribou are near town and clients are out hunting, or it is clam-digging season and clients can only be scheduled during high tide, or there is a blizzard and no one can leave their homes.

I spent part of the first day assembling the wheelchair and pouring through its manuals, warnings and cautions. I wanted to make sure I passed on all important information to Mr. Simeonie and his family as manuals do not come in the Inuktitut-language. Luckily, Mr. Simeonie was well enough the next day to go ahead with the fitting.

During the fitting, we connected with a vendor in Ottawa via telehealth (see Figure 2). He was able to help me adjust the chair remotely and give Mr. Simeonie some tips for driving. After this, we went for a road test over the December snow-covered roads. My plan for the next morning was to arrange a meeting with Mr. Simeonie and another power mobility user in town for some peer teaching and to check the accessibility of public spaces. Unfortunately the wind picked up causing poor visibility and snow drifts. The plan was can-



Figure 2. The author participates in a telehealth power wheelchair fitting session with Mr. Simeonie.

celled as power wheelchairs seem to get around okay over packed snow, but when there are drifts and soft spots the roads become dangerous and impassable. That afternoon was the annual Elders' Christmas party in the high school gym. The weather cleared a little and after lunch, Mr. Simeonie's wife called to ask if I could escort him there. I agreed, knowing that he hadn't attended this event in years and that this would give me an opportunity to follow up on his driving skills. We

started off at a gentle pace when I noticed I was walking more and more briskly and then trotting to catch up. Before I knew it he'd switched into high gear and

About the author – Janna MacLachlan, MSc (OT), graduated from the University of Western Ontario in 2006 and since that time has been a Baffin Region occupational therapist based in Iqaluit, Nunavut. She can be contacted at jannamaclachlan@hotmail.com.

was full speed ahead of me. Was he being unsafe? I assessed the situation - there are no sidewalks so he was on the road. With his parka, tuque and scarf, he couldn't really turn his head to look behind him. I yelled "siaruai", which means "wait" in Inuktitut (Mr. Simeonie was a unilingual Inuktitut speaker) and caught up with him at a stop sign. I motioned for him to stay close to the side of the road. The smile on his face left an

impression on me and he was off again. I began jogging behind him and the occupational therapist in me continued to assess the situation.

It occurred to me that this gentleman had rarely gotten out of his house in years and in more years than that had certainly not gotten around the community on his own steam. On special occasions, when well planned ahead of time and when he was feeling particularly well, family or the health centre staff would get him out by lifting him manually into the back of a cube truck. His most frequent opportunity for getting out of the house would be for appointments at the health centre or to the airport for a medical evacuation to the Iqaluit hospital – not exactly meaningful community participation. He had been dependant on others for mobility; this was his first chance in many years to go fast, to control where he went and to feel the wind on his face from his own speed. I found myself in full parka, snow pants, and big Sorel boots jogging behind a man in a power wheelchair in -20°C temperatures with the gorgeous scenery of Pangnirtung in the background and laughing hysterically at the situation. While I yelled "wait", in my head I thought "Go, Mr. Simeonie, go!"

It took non-traditional methods of service delivery and "outside the box" thinking to enable Mr. Simeonie to achieve his goal and to overcome the barriers of limited services, limited resources, and geography. Cases such as this are dealt with by remote Canadian occupational therapists on a very regular basis.

Sadly, Mr. Simeonie passed away in March of last year. His power chair is being recycled for another member of his community.

Outside the box

The Nunavut context, as demonstrated by this case, provides unique considerations for wheelchair users. I once received a phone call from an occupational therapist in an urban centre after she had provided wheelchair training to a client of mine. She recommended that the client not drive his wheelchair at night as this had not been practiced. I kindly reminded her that, as it was December and 24-hour darkness was upon us, if the client could not go out at "night", he would not get out at all.

There are also plenty of examples of creativity on the part of individual wheelchair users to participate in meaningful occupations. Some clients take their power chairs on boats and on qamotiqs (sleds pulled by snowmobile) to participate in hunting and camping. What we haven't been able to figure out yet is a design for skis for wheelchair castors – they just sink too easily into the snow! I would invite anyone who has a solution for this to contact me.

Remote occupational therapy in Canada offers clinicians unique opportunities to experience aboriginal culture, develop skills in all areas of practice, and gain immeasurable experience in thinking "outside of the box". For those of you looking for a little adventure, I highly recommend it!

Meaningful participation: CAOT's consultation for the Convention on the Rights of Persons with Disabilities



Janet Jull, CAOT Policy Analyst

The Convention on the Rights of Persons with Disabilities is an instrument of the United Nations intended to protect the international rights and dignity of person with disabilities.

On March 16th, 2010, the Honourable Lawrence Cannon, Minister of Foreign Affairs, and the Honourable Diane Finley, Minister of Human Resources and Skills Development, announced that the Government of Canada had ratified the Convention on the Rights of Persons with Disabilities at the United Nations headquarters in New York City. In doing so, Canada joined an international community voicing support for the rights of people living with disabilities.

The Government of Canada then consulted with stakeholders (such as CAOT), and provincial and territorial governments to gather information on how the ratification might affect their respective communities. Following are the questions received by CAOT from the Government of Canada and excerpts from CAOT's response document.

1. What are the greatest barriers that persons with disabilities face to participating fully within the community?

CAOT is aware that for people experiencing a mental or physical disability, the barriers to occupation and therefore full participation with their communities, take many forms. Barriers for participation of people with disabilities exist in the Canadian physical, policy, health care, and social environments (Methot, 2004).

Physical environment: Examples of physical barriers include the design and access of public buildings and transportation. Often, occupational therapists are primary care providers for people experiencing physical barriers for engaging in occupation. Therapists prescribe equipment, as well as provide training or modifications to facilitate engagement in daily occupations in the home, work and community environments.

Policy environment: Disability policy in Canada is fragmented with differing policies within government and across programs within ministries (Boyce et al, 2001; McColl & Jongbloed, 2006). The result is inconsistent access to opportunities and resources within com-

munities for people living in Canada with a disability.

Health care environment: The current health care environment does not best meet the needs of Canadians living with a disability. People with a disability do not typically require services to address illness. Instead, this population is best served by a health care system focusing on health promotion and prevention of injury and illness (WHO, 2009).

Social environment: There are many ways in which people living with a disability are excluded from full participation within their communities. System disincentives, such as disability pensions that do not allow for work trials, can interfere with productive occupations (McColl & Jongbloed, 2007). As well, attitudes of discrimination exclude people with a disability from participating meaningfully within their communities (Stienstra & D'Aubin, 2006).

CAOT believes that all Canadians have the right to explore and enjoy engagement in the occupations of their choice. CAOT works to enable social change that enables participation throughout communities. Engagement in meaningful occupations is an important determinant of health.

2. In your view, are Canada's existing laws and policies generally consistent with the provisions of the Convention?

The Canadian disability policy environments are dominated by several major statutes and programs at the federal level. Statutes such as Canada's Constitution Act, the Canada Health Act, the Employment Equity Act, the Human Rights Act, and the Charter of Rights and Freedoms define disabled people as a group whose rights are protected (Cameron & Valentine, 2006).

These services are delivered at a provincial and territorial level, meaning that differing laws and programs across the country affect people that are disabled. There are tensions between federal and provincial/territorial government in addressing the inadequacy of current resources to meet the occupational needs of disabled people.

CAOT commends the Government of Canada in taking action to address issues currently undermin-

ing the health care system and service delivery to disabled people, and encourages next steps in providing context for national consistency and equity within the law, policy and programs for people living with disabilities.

3. What benefits do you see, on an international level, flowing from Canada ratifying the Convention?

CAOT believes that Canadian international partnerships and infrastructure designed to meet the needs of people with disabilities will benefit from the process of ratifying the Convention. Canada is viewed around the world as a leader in the democratic process. Although Canadians are viewed as able to participate fully in the democratic process and live as citizens enjoying rights and freedoms, this is not always the situation for people with disabilities (Salojee, 2002; Stienstra & D'Aubin, 2006). People with disabilities are not able to act in their full capacity as citizens and are often limited from meaningfully participating in their daily life.

CAOT believes that the process of ratifying the Convention in Canada will prompt national and international dialogue on disability, and represents Canada's willingness to participate in such dialogue. Ratification creates an opportunity for all people of Canada to participate in creating a just and inclusive society so that all persons can enjoy meaningful engagement in occupations of their choice.

CAOT believes that Canada has much to offer, and to gain, through participation in the international disability rights dialogue prompted by ratification of the Convention. CAOT endorses and supports ratification of the Convention, and believes that all people have the right to engage meaningfully in their lives, with their families and communities.

4. In your view, from the perspective of the obligations set out in the Convention, what should be the key areas for federal government action related to protecting and promoting the rights of persons with disabilities?

The aim of the Government of Canada in ratifying the Convention is to promote a climate of social inclusion for Canadians with disabilities. Therefore, the Government of Canada must collaborate with people of Canada that live with a disability, as well as their representative groups, in making the process of ratification accessible, in every sense, to people with disabilities. Such engagement would enable people

with disabilities to play a meaningful role with their community, through engaging in the occupation of shaping a more just Canadian society.

CAOT advocates for access of all people of Canada to opportunities and resources to participate in occupation that is meaningful to them. The government of Canada needs to immediately find ways to engage persons with disabilities and disability organizations in the process of addressing principles outlined in the Convention, thereby protecting and promoting the rights of persons with disabilities.

5. Do you have suggestions as to how the Government of Canada could work with the disability community to promote the Convention to the Canadian public?

Occupational therapists are often acting in a special relationship of advocacy for people living with a disability. This is because the environment presents barriers to full participation of people with disabilities in the community. Therefore, to engage the members of the disability community to promote the Convention, the disproportionate impact of societal disadvantage on people with disabilities would need to be addressed. Participation in political processes would need to be accessible for those that have a disability. As well, other barriers to participation, such as inadequate disability supports/resources, role models, discriminatory views, and physical accessibility, would need to be addressed (Stienstra & D'Aubin, 2006).

CAOT understands the potential for positive impact when working with others to advance common goals, and has therefore focused on building alliances with over 35 organizations, coalitions, and task forces. Through these collaborations, CAOT actively seeks to positively influence the health and well-being of Canadians living with a disability.

Acknowledgements

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The use of lighting to prevent falls: Some preliminary evidence

Dorothy Kessler, Frank Knoefel and Rafik Goubran



The availability and use of lighting are important considerations for occupational therapists working in fall prevention. Falls are a common accident amongst the aging population. Approximately 30% of people aged 65 years and older suffer from falls annually, with 10-15% of these falls resulting in major injuries, such as fractures (Aharonoff, Dennis, Elshinawy, Zuckerman, & Koval, 2003; Howland et al., 1993; Lee, Wong, & Lau, 1999; Tinetti, Speechley, & Ginter, 1988). Approximately 40% of long-term care facility admissions are falls-related, and are associated with considerable loss of independence and diminished quality of life (Howland et al., 1993; Lee et al., 1999; Tinetti et al., 1988; Mandavia D & Newton K, 1998). Most falls occur in the home with more than one-third occurring in the bathroom and bedroom (Devito et al., 1988; Lee et al., 1999). While studies have shown that older adults fall more often during times of maximal daily activity, many older adults have decreased visual acuity, decreased mobility and increased walking aid use, which significantly affect their ability to balance and walk safely in darkened conditions (Lee et al., 1999).

Occupational therapists working in fall prevention evaluate lighting in the client's environment and may recommend the use of lighting at night as a strategy to decrease the risk of falling. However, there is little information in the literature about who uses lights at night and whether education regarding the use of lighting is effective. To determine the potential role of smart lighting technologies in fall prevention, information on who uses lighting at night following rehabilitation can enhance the intervention and education provided by occupational therapists.

Smart lighting technologies include sensor and motion-activated lights that are triggered by activities of daily living. For example, a sensor mat placed under the mattress can trigger lighting that illuminates the bathroom doorway when a person gets up during the night, thereby providing light and direction and possibly preventing falls.

The Technology Assisted Friendly Environment for the Third Age (TAFETA) Project for Older Adults Research Team (www.tafeta.ca) is a partnership among Elizabeth Bruyère Research Institute at Bruyère Continuing Care, University of Ottawa, and Carleton University in Ottawa, Ontario. This

interdisciplinary team of clinicians, engineers, and others is involved in researching a broad range of technologies that address a variety of clinical issues faced by older physically and cognitively challenged individuals.

Smart lighting technologies are one example of the technologies being trialed in the TAFETA Smart Apartment, a one-bedroom apartment operated by Bruyère Continuing Care. Other examples are motion sensors that can initiate an emergency call if a client does not return to bed after getting up at night, possibly having fallen; a talking fridge that reminds a client that she/he left the door open and is able to record activity and notify a care provider that the fridge door has not been opened in 24 hours; and SmartCells® flooring installed in the apartment's bathroom. SmartCells® flooring is comprised of rubber coils integrated below the flooring surface. It is believed to be buoyant enough to lessen the impact of a fall. The TAFETA researchers are also working on communication and storage systems that will integrate and summarize the information gathered from these technologies, and provide practical status alerts to care providers and clinicians.

Research

A study was conducted in the TAFETA Smart Apartment that evaluated user preference of smart lighting technologies as options to assist older adults to navigate in the dark. It was noted in this study that some participants, when provided with a "no lights" option, did not turn on any lights and ambulated to the bathroom in the dark. The authors wanted to know if there were specific characteristics that could be used to identify these "risk-takers."

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This information could assist clinicians to plan interventions more efficiently and effectively.

For the study, simulation of night was achieved by closing doors and covering windows. The smart lighting technologies used were: (1) the Lited Pathway® system consisting of illuminated strips located around the door frame to the bathroom, and (2) a fading light system illuminating both the bathroom and bedroom. Both systems work with a pressure sensor placed under the mattress and a motion detector to turn the lighting systems on/off.

Thirty-six participants, 22 women and 14 men, were recruited from the Bruyère Continuing Care stroke, geriatric and neuro-musculo-skeletal in-patient rehabilitation programs, and the Geriatric Day Hospital program. The average age of participants was 76 with ages ranging from 54 -93 years of age. To be included in the study, participants needed to be 50 years of age or older; able to provide consent in French or English, and be able to ambulate and complete bed transfers with supervision or cueing. Legally blind participants were excluded.

Participants were interviewed to obtain information on health and home lighting and bathroom visit habits prior to hospitalization, and were then tested with simulated night-time trips to

Figure 1. Comparison of participants who did not choose lighting pre and post rehabilitation.

	“Light Off” Pre-Rehab (21)	“Lights Off” Post-Rehab (10)	P Value
Age >75 years	52.4% (n=11)	50.0% (n=5)	P=1.0
Stroke	61.9% (n=13)	60.0% (n=6)	P=1.0
Orthopaedic	19.0% (n=4)	10.0% (n=1)	P<0.6
Walking Aid Use in Home	38.1% (n=8)	50.0% (n=5)	P<0.5
Walking Aid Use in Room	85.7% (n=18)	100.0% (n=10)	P<0.25
Sense of Insecurity	14.3% (n=3)	30.0% (n=3)	P<0.1

the bathroom under different lighting conditions: Lited Pathway® illuminated strips, Austco fading light solution, and no lighting. Six test scenarios which varied the order each lighting condition was experienced were established and participants were randomly assigned to one of these scenarios. For each of the scenarios, participants had the option of turning on standard room lights.

Of the 36 clients who took part in the study, 21 (58%) did not previously use lights at home to travel to the bathroom during the night. Of these, 11 (52%) chose to use lights while 10 (48%) continued to mobilize in the dark post-rehabilitation. Table 1 presents the results of the analysis.

Clinical relevance

It is interesting to note that of the 21 clients not using lights prior to rehabilitation, approximately half chose to use lighting during the study. Only ten continued to mobilize in the dark. These results do not provide insight into what contributed to the choice to use lighting for the eleven clients who changed. Also of note is that age was not a factor in determining whether to use lighting at night.

Although results were not statistically significant, some findings suggest issues of clinical significance. For example, it is unclear why a high percentage of clients with strokes, those using walking aids and those feeling insecure continued mobilizing in the dark despite rehabilitation. Potential reasons to consider when reflecting on practice in this area include the following:

- Clients with stroke may have deficits such as impulsivity or decreased insight into their abilities which could impact on their choice to use lighting.
- Clients who used a walking aid may gain a sense of security from the device and/or may not have a free hand to turn on a light.
- Clients may require a different therapy approach to facilitate changing their lighting habits.
- Therapists working in stroke rehabilitation may focus more on improving abilities including equipment for independence and safety, with less focus on falls prevention. By contrast, those clients admitted with orthopedic conditions are frequently admitted as a result of a fall and therefore may have received more in-depth falls prevention training. Occupational therapists working in stroke rehabilitation may want to examine how they address fall prevention in their practices.

- The study environment/design may have influenced the choice of lighting use. Clients may have felt more secure in a supervised hospital environment, or the night simulation may not have sufficiently simulated “real life”: actually waking up and needing to accommodate to light.

Occupational therapists may use the results of this study to reflect on their practice with clients and, in doing so, consider whether their clients need specific interventions aimed at the use of lighting at night for fall prevention. Clients requiring occupational therapy guidance to increase their use of lighting when traveling in the dark may benefit from the application of smart lighting technologies in a clinical or home environment.

The described study begins to provide insight into factors influencing rehabilitation clients’ use of lighting for mobility at night, though the sample size was small. Further investigation is required to confirm and build upon these findings.

Please contact the author if you would like more information on the study design.

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Column Editors: Jonathan Rivero &
Christel Seeberger

Occupational therapists as clinical care managers with Veterans Affairs Canada

Marion Hutton

Clinical care managers (CCMs) provide intensive case management services to Veterans Affairs Canada (VAC) clients with complex mental health needs. These clients often have serious symptoms, co-morbid conditions, are disconnected from supports and services in their communities, and struggle in various areas of their daily lives. Helping these clients manage their needs requires an intensive level of case management to assist in the coordination of services and provision of regular support and guidance.

The role of the CCM is to use their expertise to assist the VAC Case Manager (the primary case manager) with the implementation of the VAC case plan for the client with complex mental health needs by:

- building a strong supportive relationship with the client and/or family,
- assisting the client with follow-through on the case plan objectives,
- being a personal link to community resources,
- promoting access to necessary treatment services,
- providing regular support to the client,
- collaborating with the VAC case manager,
- consulting with other health care providers.

The CCM does not provide clinical therapy or counseling. The VAC case manager, in consultation with the District Office interdisciplinary team and the

Regional Mental Health Officer, makes decisions on whether a particular client could benefit from CCM services.

For the last two years, over 160 psychologists, social workers and nurses have been available across the country to provide CCM services. In September 2009, VAC identified occupational therapists as another professional that may adopt the CCM role and is now

registering licensed occupational therapists (with a minimum Bachelor's degree in occupational therapy) who have a minimum of five years of experience in community mental health.

Dr. Tina Pranger, occupational therapist and National Mental Health Program Officer at VAC describes her role in evolving occupational therapists into the CCM role:

"I was Manager of the Rehabilitation Program at VAC for three years when I moved to the Mental Health Directorate and became aware of the CCM role. When I saw the role, it said occupational therapist to me, a perfect fit for our profession. Fortunately, one of my job tasks was recruitment of CCMs. It was in this capacity that I advocated for and worked towards getting occupational therapists involved in that role because initially it was just psychologists, social workers and nurses."

In the last six months, since the role of CCM was opened to occupational therapists, there have been 73 occupational therapists registered as CCMs across Canada.

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About the author –

In 2003 Marion established Life Care Planning (LCP) as the only multi-disciplinary occupational rehabilitation in the NWT and Nunavut. LCP has grown to become an established company providing disability management services to large employers such as those in the diamond industry, as well as lawyers and insurance companies.

In 2009, a web portal of internationally educated occupational therapists was launched and a short webinar of Marion's experiences was profiled. In addition, the Akaitcho Business Development Corporation named Marion "Youth Business of the Year". Marion is the Board Director for the Territories.

The Canadian Falls Prevention Curriculum: An on-line interdisciplinary learning opportunity

Mary Lou Boudreau

The Canadian Falls Prevention Curriculum is an on-line course that takes an interdisciplinary view of falls prevention, presenting the evidence base for the development of a falls prevention program. The course was developed by Dr. Vicki Scott and her team under a grant from the Public Health Agency of Canada, and extensively field tested during its development.

The course is organized to take the participant through all the steps of creating a fall prevention program, and to give them data and resources at every step. The first module is “defining the problem”, which goes through definitions, statistics, how to use statistics, and what statistics you might gather from your own setting. The next section focuses on “risk factors”, which has you identify the risks in your own type of setting (acute care, long term care, community, etc.). Following is a module that presents an intervention unit that complements the Canadian Model of Occupational

Performance and Engagement (Townsend & Polatajko, 2007) and focuses on best practices. The fourth module discusses program implementation, and the last section talks about evaluation. Participants select a case study at the beginning of the course. At

the end of each module, participants apply what they have learned to the case study. A program has been developed from inception to evaluation by the end of the course.

Now that the course is being offered on-line, it is accessible to individuals, on their own time, in their own site. Another option would to take the on-line course with a group from the same setting. Because this course applies the information to a case, a group could use their own situation as the case example and work through the development of a program that could actually be run in their place of work. The link for more information on the on-line course is:

<http://www.uvcs.uvic.ca/aspnet/Course/Detail/?code=HPCF215>

Another option is to have a fact-to-face course run in your city. Each province has a lead agency with a list of certified facilitators, and would be happy to work with you to plan a course. To find the lead organization in



your province, go to:http://www.injuryresearch.bc.ca/admin/DocUpload/3_20090130_100614Provincial%20Leads.pdf

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Column Editor: Heidi Cramm

Inclusive environments: The role of occupational therapy

Katie Semple, Beth Blowes, Elizabeth Steggles and Sue Baptiste

Accessibility has meaning beyond access to the physical environment and involves enabling dignified inclusion in services, activities, and relationships. Accessibility is a broad area in which occupational therapists have exceptional opportunities for profes-

sional input. In meeting the requirements of the Accessibility for Ontarians with Disabilities Act (2005) (AODA), the demand for accessibility consultants in Ontario will likely increase, and occupational therapists seem ideally suited to meet this need. Occupational therapists are well suited for this field because of their understanding of function, disability, and the interplay among person, environment, and occupation (Ringaert, 2002). Occupational therapists should play a key role in addressing matters of accessibility and universal design since these directly impact occupational performance (Canadian Association of Occupational Therapists [CAOT], 2009; Ringaert, 2002).

This article describes a 2009 final occupational therapy student project, which was part of an Accessibility Audit that commenced in 2007 at McMaster University. Experiences from the 2007 project were reported in a past article (Adam et al., 2008). Based on the outcomes of the project, there is a perception that occupational therapists are not as involved with accessibility as they could be. The results from past projects, in combination with a detailed review of the literature, have demonstrated a need to explore the role of occupational therapists in the area of accessibility and creating

inclusive environments.

Interviews

After gaining consent, semi-structured interviews were conducted with 12 occupational therapists and other professionals working in the area of accessibility. The occupational therapists interviewed had between 8 to 38 years of experience working as an occupational therapist. The other professionals interviewed had worked in the area of accessibility between 7 to 36 years. Interviews, which ranged from 15 to 60 minutes, were transcribed and coded to identify themes. There were no notable differences in the answers provided by the occupational therapists and other professionals.

Results

Themes generated from the interviews included the current role of occupational therapists in accessibility, the future role of occupational therapists in accessibility, skills possessed by occupational therapists, barriers to fulfillment of the role, occupational therapy education regarding accessibility, and professionals working in the area of accessibility. Each theme is described in detail below.

Current role of occupational therapists in accessibility

The majority of participants reported that occupational therapists currently work one-on-one with individual clients to address accessibility. One participant indicated that “occupational therapists, by definition, work with individuals.” The most common environment in which occupational therapists currently work, as described by participants, is the home, primarily assessing for home modifications. Participants also discussed the role of occupational therapists in helping clients find resources, as well as enabling clients to make appropriate decisions and understanding their needs relating to accessibility. Some occupational therapists are working in consultative roles, that includes assisting contractors in ensuring that spaces are accessible. In that regard, one participant noted, “The role of the occupational therapist is to help the contractor design for tomorrow rather than

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Sue Baptiste, Professor at McMaster University, is one of the founding members of Accessibly Yours, the School of Rehabilitation Science's consultation service, and has a deep commitment to inclusiveness in society.

for today.” This quote demonstrates the ability of occupational therapists to contribute positively and bring a unique perspective to this area of expertise. Some participants discussed the limited involvement from occupational therapists concerning broader accessibility issues; however, occupational therapists’ current role as advocates for change was highlighted in the interviews.

Future role of occupational therapists in accessibility

The majority of participants stated that occupational therapists have a potential role in the area of accessibility in all types of environments where occupations take place, if they are educated in that area. This is highlighted in the following participant statement, “it would make sense that any environment where occupation is taking place would be an environment that we would potentially look at for accessibility.” Similarly, it was indicated that occupational therapists can be involved at multiple levels if they have gained the required expertise. Examples of the levels at which occupational therapists can be involved include working on accessibility committees, acting as consultants, completing physical audits, taking a leadership role at the policy level, drafting, and being involved with planning. Participants discussed the potential role of occupational therapists in educating various groups. This included developing resources

and linking individuals to information relating to accessibility. Occupational therapists can also act as facilitators and bring groups together, by bridging the gap between design professionals and people with disabilities. The idea of advocating was also discussed as an important future role for occupational therapists. This would involve ensuring access for everyone in all types of environments, regardless of ability level.

Skills possessed by occupational therapists

Participants identified a number of skills possessed by occupational therapists that position them well in the area of accessibility. It was indicated that occupational therapists have a strong awareness of disability and are able to identify specific client needs. This includes knowledge of a broad range of clients’ ability levels, which is necessary when creating inclusive environments. This is demonstrated in the following participant quote, “if you are going to develop a policy, then the occupational therapists should definitely be in there because we know what the clients need.” In addition to an awareness of individuals and their varied needs, occupational therapists are also mindful of the influence of the environment on individuals’ ability to engage in occupation. This directly applies to accessibility, as evidenced in the following participant statement, “we have that view of the person, the environment, and the occupation, and fitting all three of those together, which to me is accessibility.” Other skills identified by participants include advocacy, leadership, analytical, and communication skills, as well as dedication to lifelong learning and finding current evidence-based resources.

Barriers to fulfillment of the role

The major barrier to occupational therapists’ involvement in accessibility issues as identified by participants was a lack of education on multiple levels. This included a lack of awareness on the part of other accessibility professionals regarding the skill set of occupational therapists. In addition, participants noted that occupational therapists may not recognize their own abilities in this area, which is further compounded by a lack of accessibility education in occupational therapy programs. Furthermore, participants discussed the lack of action by occupational therapists to take opportunities and promote their skills in the area of accessibility. One participant reported, “occupational therapists aren’t very good at putting themselves forward and making a case for themselves as a business person.” Another participant encouraged occupational therapists to take action by stating,



“come on now, let’s move and advocate and market to occupational therapists, as well as others about what we can do.” Some participants expressed fear of involvement in political issues, leading to a lack of occupational therapists situated in positions of power. Feelings of powerlessness may also lead to inaction, as it may be easier to simply ignore the issue.

Occupational therapy education regarding accessibility

Opinions were split regarding whether occupational therapists receive adequate education in the area of accessibility. Some participants believed that student occupational therapists are exposed to the area; however, as students graduate as generalists, there is an expectation for continued professional development. Other participants suggested that there should be more instruction of practical skills relating to accessibility, such as auditing and drafting. This is highlighted in the following participant quote, “occupational therapy programs need to teach particular skills and augment problem-based learning with skills in auditing, standards, policies, legislation, and codes.” As accessibility is an emerging area that is constantly evolving, this is a challenging subject matter to fully address in a two-year occupational therapy program. Some participant suggestions for improvement in occupational therapy education include more collaboration between occupational therapy schools and contractors and creating more opportunities for students to pursue additional interests as lifelong learners.

Professionals working in the area of accessibility

The following is a list of individuals identified by participants as common key players in the area of accessibility:

- Consumers
- Funders
- Architects
- Engineers
- Interior designers
- Manufacturers
- Contractors
- Social workers
- Accessibility consultants
- Municipal planners
- Physiotherapists
- Policy makers
- Trades people

Conclusions

Participants in this project believe that occupational therapists currently have a role in the area of accessibility, particularly when working with individual clients in the home environment. As demonstrated by the opinions expressed by participants, occupational therapists can also become involved at a broader level, such as assisting in the creation and implementation of accessibility standards. CAOT has developed a position statement on universal design and occupational therapy (CAOT, 2009). Suggestions made within the position statement are mirrored by ideas generated by participants from this project. This includes occupational therapists developing partnerships with key players in accessibility, advocating for the creation of inclusive environments, becoming involved at the policy level, and educating others about the role of occupational therapy and the importance of inclusiveness (CAOT, 2009).

To become more involved in accessibility issues, occupational therapists need to recognize their role and advocate for their involvement. It was identified in this project that occupational therapists’ ability to work in this area may be limited by a lack of self-promotion, that would otherwise enable other professionals to recognize the value of occupational therapy. Occupational therapists may be ideally positioned to contribute to the area of accessibility and creating inclusive environments, due to their skill set and unique perspective. Accessibility directly relates to occupation and, therefore, this is an area that cannot be ignored by occupational therapists or the potential role will be lost.

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Column Editor: Lili Liu and Misako Miyazaki

To be or not to be on Facebook: That is the question

Rashid Kashani, Susan Burwash and Anita Hamilton

Health care professionals have a mandate to continually improve professional knowledge and skills, much of which is dependent on networking skills. In the last decade, our capacity to network with colleagues has been enhanced by expansion and improved usability of online technology. As the knowledge era arrived, so did interactive online tools including databases, discussion forums, informative blogs, wikis and online communities, allowing us to acquire, share and generate knowledge from our home or work space.

Concerns that some occupational therapists have about using online tools for collaboration and networking are centred on confidentiality, professionalism and self-protection (Baerlocher & Detsky, 2008). A simple way to overcome these concerns is to create closed and protected online communities. However, this can be costly, overwhelming, time consuming and therefore prohibitive for most individuals or agencies. As a result, using mainstream online technologies for professional networking has emerged as a viable option.

Facebook is an online community with over 400 million unique users (Facebook, 2010) and is the premier site in the English-speaking world. This article will explore current uses of Facebook by occupational therapy

practitioners, academics and students, suggest a set of guidelines for using this particular online community to ensure we uphold our professional code of ethics while enhancing professional development and networking, and present two case scenarios illustrating ethical considerations.

About Facebook

Facebook is a social networking site that allows members to create an individual profile, a 'group' around a special interest or a 'page' to disseminate information about a person, group or product. Presently there are over 1000 groups or pages related to occupational therapy in Facebook. Group pages range from 1 or 2 members or 'fans' to almost 6100 fans of the American Occupational Therapy Association's page. The majority of groups and

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Table 1: Selected Facebook groups and pages.

Name of Group/Page	Description of Site	Number of members / fans
Facebook Occupational Therapy Association (FOTA)	Largest OT group on Facebook. An initiative by AOTA to increase consumer awareness of OT	14 201 members
Collaborating & Sharing Ideas With Other Occupational Therapists	"You can brainstorm here! Talk to other therapists and see what they think or if they can help you out!"	6132 members
British Association and College of Occupational Therapists	"We are here to help and guide our members throughout their studies and careers."	2215 fans
OT • Occupational therapy	Purports association with WFOT. However ,unclear if this is true	3150 members
American Occupational Therapy Association	Official fan page for AOTA	6099 fans
American Occupational Therapy Association	Official group page for AOTA	2751 members
OT 4 OT	Group for OTs who are early adopters of online technology	420 members
YogOT	Group for OTs and OTAs interested in clinical applications of yoga	86 members
MiSTERS OF OCCUPATIONAL THERAPY	A group for male OTs. But has a lot of female participants as well. Started by a B.C. occupational therapist	181 members
MHOTCoP	A group originally set up for mental health OTs in Alberta, Canada	11 members
ADVANCE for Occupational Therapy Practitioners	"Committed to helping therapists enhance their impact on the health-care industry."	2268 members
Occupational Therapists 4 Micro-credit	Occupational therapists interested in micro-credit	10 members

Table 2: Facebook pros, cons and cautions

Positive aspects of Facebook:	Potential negatives aspects of Facebook:	Cautions:
-sense of knowing what others are doing	-somewhat addictive	-applications can access your information
-ability to start a special interest group or fan page	-social “not-working” (being on social-networking websites, and not working (Urban Dictionary, 2009)	-consider who made the application and for what purpose
-getting information about OT out where people are really spending time	-time waster	-applications can produce SPAM
-instant messaging in chat, not stored for long, or at all	-potential identity theft	-netiquette of making friends and ignoring requests
-can be more private than email	-too much information about people with whom you are friends	-privacy issues
-way of getting grassroots connections	-vulnerable client users may be prone to manipulation	
	-exclusion of Facebook nonusers	
	-not always being used as intended	
	-every time there is an update privacy settings require resetting	

pages have been developed by student groups, national associations, health care recruiters and special interest groups. Few occupational therapy academic programs have created official pages or groups; however, many occupational therapy students set up pages as a way to share information with their classmates. Table 1 lists some selected occupational therapy-related groups or pages while Table 2 outlines the pros, cons, and cautions of using Facebook.

Does what happens on Facebook stay on Facebook?

All information that you upload to Facebook is potentially available to any Internet user. Therefore maintaining privacy settings and keeping up to date with changes to Facebook policies is extremely important. Facebook users have ways to increase the likelihood that what happens on Facebook stays on Facebook, and is only shared with individuals whom they chose. However, diligence is required by users as default settings for Facebook accounts mean that information is potentially shared with anyone on the Internet. In addition to the concern surrounding what remains private and

what is shared, it is important to realize that, at the time of writing of this article (February, 2010), Facebook accounts closed at the request of users are not permanently deleted but are archived and stay on Facebook’s server. So to answer the question “Does what happen on Facebook stay on Facebook?” the answer is “yes”, all information stays on Facebook as an archive rather than being deleted, and “no” it does not necessarily stay just within Facebook, it can be copied and shared with others if account privacy settings are not set at a high level. Information about how to set up a Facebook account is outlined in Table 3 and information about how to check privacy settings are outlined in Table 4.

Ethics

There are a variety of ethical questions emerging as a result of use of social networks. Concerns include protection of one’s own information as well as privacy issues that arise when a supervisor, preceptor or instructor sifts through online information of someone with whom they are not directly connected. There are added ethical dilemmas as occupational therapists. For example, who

Table 3: Setting up a Facebook page.

1.Go to https://www.facebook.com/ (Note: the ‘s’ indicates connecting to a secure site)	3.Go to “Privacy” settings
2.Fill in the information on the main page	4.Set all components to “Friends only”

Table 4: Protecting yourself.

-Keep postings and personal information shared at the level where you will not have to repair your identity
-Identity presentation. Is this honest and accurate?
-Multiple personalities. Consider setting up an account for professional use and another for social networking, especially if you have existing separate work and personal e-mail accounts
-Dealing with friend requests will depend on the context. If the answer cannot be found in ethics guidelines, develop some self-monitoring rules. For example, accept all friend requests from students previously preceptored on fieldwork, or none at all
-Be aware that you may not automatically have a right to use information found online given recent rulings of the Office of the Privacy Commissioner of Canada

should be added as a friend? Should use of this media be limited to family and friends? What about adding colleagues and students?

These decisions have the potential to blur professional and personal boundaries and separation of the real and virtual representation of oneself. Studies involving medical students and their Facebook profiles reveals fewer than 38 percent had set their privacy to protect personal information, including home address, sexual orientation and political perspectives (Thompson et al., 2008). This same study reports up to 70 percent of profiles reviewed contained material that could be deemed negatively, including portrayals of excessive alcohol consumption, overt sexuality and patient privacy violations. A subsequent letter to the editor of this same journal recommends a national conversation be facilitated to produce general guidelines for physicians to draw upon in using social networking sites (Gorrindo & Groves, 2008).

Privacy of online information has also garnered considerable Canadian attention. Facebook has had to address a complaint made by the Office of the Privacy Commissioner of Canada, alleging the social networking service had committed up to 22 privacy breaches. The complaint includes several issues with how information is used, stored and shared with third parties, even after information has been deleted by a user (Office of the Privacy Commissioner of Canada, 2009). One proposal made by Facebook to the Privacy Commissioner of Canada is that they will develop a future option to delete versus deactivate accounts. This is not yet an option for Facebook users, but is a potential future development; meaning that third parties can still obtain information, even from deactivated accounts. Similar concerns exist in the United States regarding unintended Facebook use and have resulted in some universities blocking the site (Read & Brock, 2006). In another report, lawyers advised against administrators using the site to monitor student behaviour for fear of litigation (Van Der Werf & Martin, 2007).

Other ethical quandaries can be addressed by reviewing and applying national guidelines developed by the Canadian Association of Occupational Therapists (CAOT, 2007) and further reinforced by provincial codes of ethics, such as those developed by provincial organizations across Canada. Examples of provincial guidelines readily available for public viewing include those of the Alberta College of Occupational Therapists (ACOT, 2005), College of Occupational Therapists of Ontario (COTO, 2002) and the Ordre des ergotherapeutes du Quebec (OEQ, 2009). Specific guidelines from CAOT (2007) encouraging caution for the following uses of Facebook include:

- using professional communication with clients,

colleagues, partners and stakeholders,

- ensuring confidentiality and privacy of others personal information,
- recognizing and managing issues related to conflict of interest, and
- abiding by legislative requirements and codes of ethics established by provincial occupational therapy regulatory organizations, as applicable, and other organizations to which the member has obligations.

In addition to guidelines serving to limit behaviour, other CAOT (2007) guidelines potentially encourage therapists to use Facebook:

- contributing to interdisciplinary collaboration and development of partnerships to advance the occupational performance of populations,
- promoting the profession to the public, other professional organizations and government at regional, provincial and federal levels, and
- contributing to development and/or dissemination of professional knowledge.

The sample of provincial ethics guidelines also serves to delineate behaviour while using this medium, including safeguarding client information from unwarranted disclosure and avoiding any activity or relationship which would exploit or cause harm to another person or to the profession.

For example, ACOT (2005) ethics guidelines state that inherent in the client-therapist relationship is differential power that can be exploited. As occupational therapists we should, therefore, not engage in any forms of relationship with clients that could potentially cause harm or exploit the relationship. Such forms of relationship could include using Facebook for financial, personal, sexual, material or business purposes with clients. Even virtually, engaging in such activities would be exploiting the therapeutic relationship. See Table 5 for case scenario examples.

Conversely, the provincial sample of ethics guidelines as outlined could also be interpreted as incentives for using this media as a means of improving the knowledge base of the profession. As occupational therapists, we need to be cognizant of how we contribute to the body of knowledge of occupational therapy. These provincial guidelines state that through a variety of media, we can share our experiences and influence development of our body of knowledge. In-servicing, newsletter submissions, panel discussion participation, student supervision, and clinical research are examples of activities listed in these guidelines (ACOT, 2005). As a profession, it is timely to consider updating our practice guidelines to also

Table 5: Case scenarios: Potential ethical dilemmas.

Case 1: An occupational therapist working in a school setting completes an assessment on a child with the child's mother in attendance. The occupational therapist and the client's mother discuss the assessment findings and collaborate on a planned course of action. Later that evening, the client's mother searches online for information about the occupational therapist, and finds the occupational therapist's Facebook page. There are no privacy settings and all of the occupational therapist's information, pictures, videos and wall posts are visible to anyone. The client's mother is highly offended by some of the content she reviews, significantly affecting her impression of the therapist and causing her to question if this is someone she wants involved with her daughter.

Issues:

1. Privacy setting of the Facebook account. Privacy controls on Facebook have been established to limit public viewing. In this case, they should have been used to limit the visibility of the content of a personal page to only those that have been identified as 'friends'.
2. Visible and posted content. Given that third parties, social connections and potentially the public can access posted information, precautions should be in place to prevent private content from being posted.
3. Accessed information. The parent in this case was using a social networking site to research someone's professional standing. This needs to be kept in mind when posting private information on the Internet.

Case 2: An occupational therapist using Facebook discovers Canadian Musician, Matthew Good, is on Facebook. He is open about living with a diagnosis of bipolar disorder. He is also an advocate for mental health and has a number of links on his fan pages to blogs relevant to occupational justice, mental health and innovations in electronic media. The occupational therapist becomes a fan of the artist on Facebook, posts the link to the artist's blog page and a number of other current links to resources, community-based initiatives and government studies

Potential issues:

1. The client/therapist relationship divide may become blurred in this situation. The occupational therapist would be ill-advised to enter into a treating relationship with the artist if a social relationship, even virtual, develops.
2. The disclosure of information may not be intended for a therapeutic relationship. However, the artist has made his information part of a public basis of advocacy and discussion. This public accessibility of the information encourages discussion and dissemination of information. In addition, occupational therapists are ethically responsible to participate in improving their knowledge base in topical areas.

include ethical use of electronic media, such as Facebook, and keep in step with global trends.

So, should you be on Facebook?

Adopting online technologies to network and build online communities of practice has both risks and benefits for professional practice. Online social networks such as Facebook offer a fast and easily accessible online space to form communities of practice while also enabling us to work towards enhancing public awareness of occupational therapy. When using online social networks we need to be cognizant of upholding professional ethics and preserving boundaries between our professional and personal lives. Effectively managing our relationships, real or virtual, and managing what information is available online both contribute to ensuring our visible online image is professional. We have outlined steps each individual can take to ensure that they can experience the benefits of online social networking while managing the risks to maintain the boundaries between private and professional life.

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Enabling Occupation II updates 2010

Janet Craik, CAOT Director of Professional Practice

In 2007, CAOT published the latest practice guidelines *Enabling Occupation II: Advancing an Occupational Therapy Vision of Health, Well-Being and Justice Through Occupation* (Enabling Occupation II) (Townsend & Polatajko, 2007). Key models were introduced in an attempt to advance this profession's ability to describe itself. With feedback from CAOT members, updates have been made to two models that appear in three figures. The updates more accurately reflect the text and enhance the graphic representation of enablement in the Canadian Model of Client-Centred Enablement (CMCE), and the core process in the Canadian Practice Process Framework (CPPF) for enabling occupation with individuals, families, groups, communities, organizations, and populations.

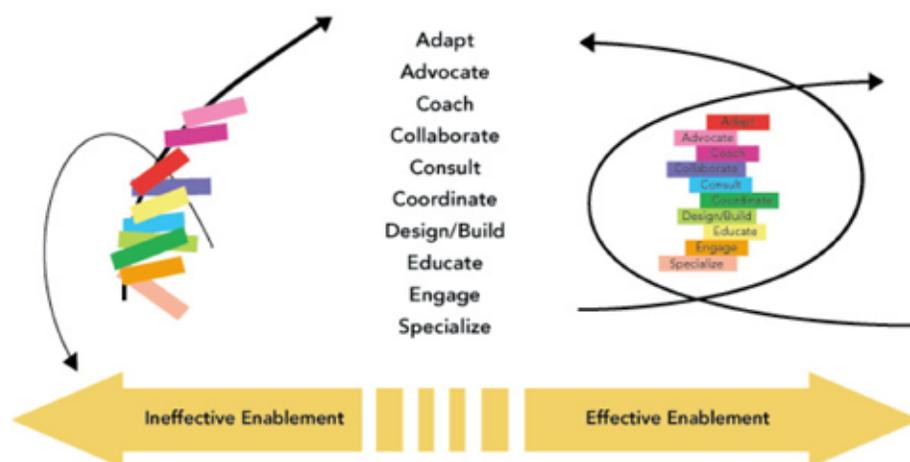
The CMCE specifies the core competency in enablement. Figure 4.4: Enablement continuum and Figure

4.5: Four decision-making points on a disablement-enablement continuum offer a continuum of possibilities from ineffective to effective enablement. The following updates were made to these two figures to reflect the text presented in chapter 4 of *Enabling Occupation II*.

Figure 4.4

1. The size and colouring of the enablement skill bars were adjusted for consistency.
2. The outer, elliptical lines for 'Ineffective Enablement' were redrawn with unequal thickness to represent the unequal relationship in which the professional overwhelms and dominates the client. The thin, weak client line ends lower than it started to convey that harm or undermining may actually occur so that the client may be actually worse than at the start of the relationship.

Figure 4.4 Enablement continuum



Townsend, E. A., Whiteford, G., Polatajko, H. J., Craik, J. & Hocking, C. (2007). Enablement continuum. In E. A. Townsend & H. J. Polatajko, *Enabling occupation II: Advancing an occupational therapy vision for health, well-being, & justice through occupation* (p. 129). Ottawa, ON: CAOT Publications ACE.

Figure 4.5

1. The updated figure 4.4 was inserted in top left quadrant.
2. Top right quadrant was labeled “Missed Enablement”.

3. All of the coloured enablement bars were inserted in the “Missed Enablement” quadrant to demonstrate that sometimes the competencies may be one-sided, that is used by the therapist without effectively collaborating with the client.

Figure 4.5 Four decision-making points on a disablement–enablement continuum

Ineffective Enablement

- negative & potentially destructive
- knowing best with limited input
- co-dependence
- alienation through expert dominance, overbearing zealotry, misunderstanding
- fractured relations, value clashes
- incongruence, non-resonance, unresponsiveness, irrelevance
- potentially offensive
- ineffective use of resources
- accountability skewed to interests for cost cutting, safety, etc., little mediation of client interests



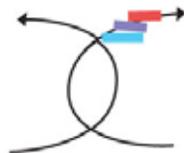
Missed Enablement

- mutual agreement of no need for professional enablement OR
- missed opportunity, vision, conditions for enabling OR
- insufficient resources: human or financial
- unsuitable sociocultural, physical, and/or emotional conditions
- unsuitable accountability for what might have been done



Minimal Enablement

- non-generative
- single-issue focus
- mechanistic, prescriptive, risk averse to just-right-challenge
- over-reliance and faith in expert’s definition and prediction of risk
- socio-cultural restrictions
- minimal resource allocation
- accountability stresses technical interventions



Effective Enablement

- positive and generative
- mutual & valued process
- mediated, negotiated values, beliefs, etc.
- congruence & resonance
- seizing opportunities, new possibilities
- balance risk taking, just-right-challenges
- appreciative of limited knowledge regarding risk
- shared expertise & responsibility
- grounded in hope
- attentive to structured inequity, diversity, injustice in enabling individual & social change
- accountability for enablement conditions, processes, & outcomes



Townsend, E. A., Whiteford, G., & Polatajko, H. J. (2007). Four decision-making points on a disablement–enablement continuum. In E. A. Townsend and H. J. Polatajko, *Enabling occupation II: Advancing an Occupational Therapy Vision for Health, Well-being, & Justice through Occupation* p. 129 Ottawa, ON: CAOT Publications ACE.

Figure 9.1

The CPPF represents the core process of occupation-based enablement as displayed in Figure 9.1. The following updates were made to the CPPF figure to reflect the text presented in chapter 9 of *Enabling Occupation II*.

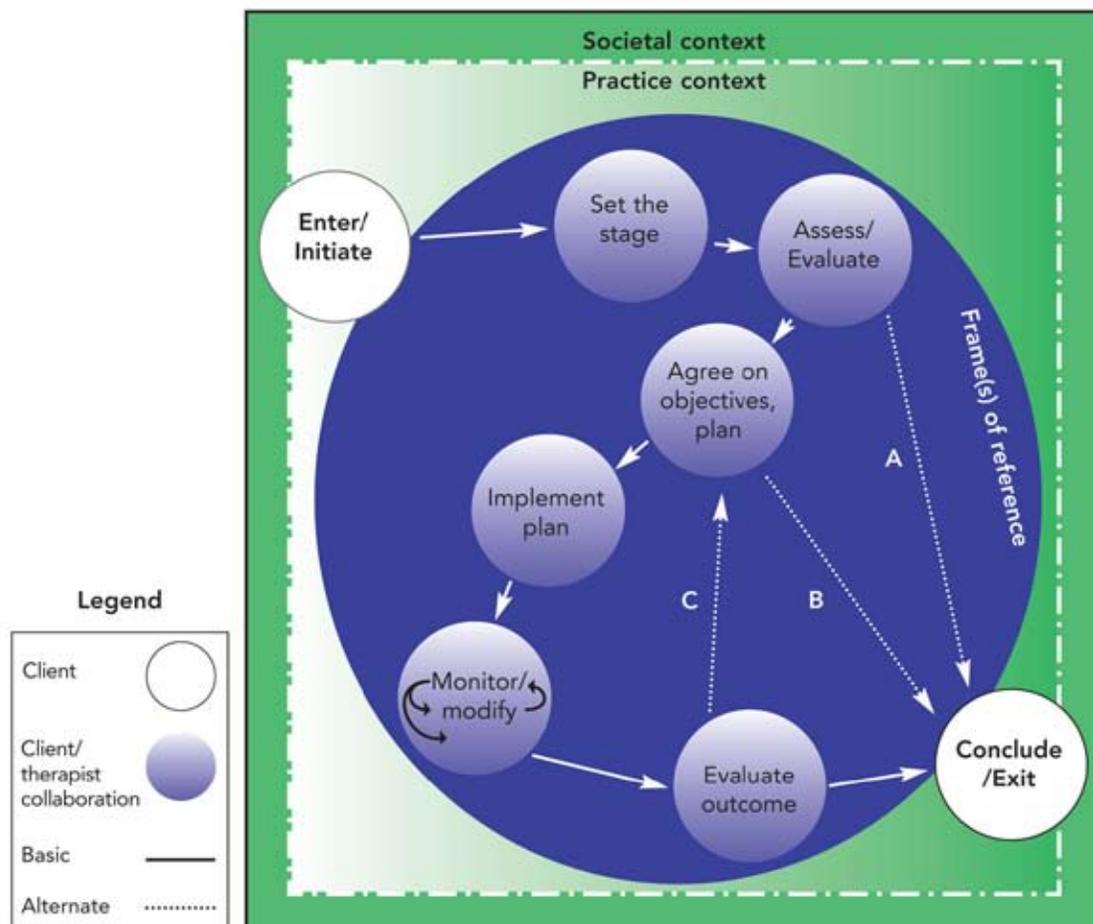
1. The alternate pathways were labelled “A”, “B”, “C”.
2. In the legend the client was represented by a white circle and the client/therapist collaboration was represented by a shaded circle.
3. In the “Monitor/Modify” action circle arrows have been inserted to emphasize the iterative process at this action point.

represented by a shaded circle.

3. In the “Monitor/Modify” action circle arrows have been inserted to emphasize the iterative process at this action point.

The updated figures have been posted on www.caot.ca. You are encouraged to visit the website and print off the new images for your reference.

Figure 9.1 Canadian Practice Process Framework (CPPF)



Polatajko, H. J., Craik, J., Davis, J., & Townsend, E. A. (2007). Canadian Practice Process Framework. In E. A. Townsend & H. J. Polatajko, *Enabling occupation II: Advancing an occupational therapy vision for health, well-being, & justice through occupation* (p. 233). Ottawa, ON: CAOT Publications ACE.



Building workforce capacity for occupational therapy in Canada

Claudia von Zweck, CAOT Executive Director

Occupational therapy as a profession provides a unique and valued contribution to health and well-being through the enablement of occupations needed and desired in life. The leadership needed to reach our potential with this professional mandate requires a workforce that has the capacity to meet population needs, a culture of professional scholarship and accountability, and a supportive funding environment (Townsend et al., 2010). Given the importance of workforce capacity for attaining success in enabling occupation, how as a profession can we proactively plan to address population needs for occupational therapy? As global economies struggle in a period of austerity, how do we continue to engender continued growth and development of the occupational therapy workforce?

Effective workforce planning requires a proactive and coordinated approach involving a broad range of stakeholders, including professional associations, regulators, employers, governments, educators, as well as individual occupational therapists and the public. This paper outlines considerations for building workforce capacity to promote coordinated planning, with examples of strategies drawn from Canadian occupational therapy organizations.

Workforce planning models

Building workforce capacity for occupational therapy begins with understanding forecasting models used for human resources planning in Canada. Efforts to develop such workforce models have occurred primarily in the past decade, prompted by reports of shortages of health professionals in Canada in over 20 disciplines, including occupational therapy, medicine, nursing, pharmacy, physiotherapy, radiography and medical laboratory technology (Kirby & Lebreton, 2002). Workforce modeling is now used to some degree in all Canadian provinces to contribute to effective workforce recruitment and retention strategies and attain better alignment between education program offerings and system needs. Forecasting however remains an inexact science and there is little sharing of models between jurisdictions (Cameron Health Strategies Group, 2009).

Simple approaches for estimating workforce needs involve adjusting counts of existing professionals for population growth and size. Such utilization models are criticized for the assumption that the current dis-

tribution of professionals is optimal for serving population needs. Needs-based modeling is proposed as a preferable human resources planning approach and uses identified needs within a population to predict workforce requirements (Lavis & Birch, 1997). However, while many needs may exist within a population, services to address the identified issues may not be valued or alternatively, may not be feasible as result of factors other than availability of human resources (e.g., available funding). As a result, many forecasting methods combine population health, utilization and effective-demand measures to forecast services considered to be needed, desired and viable within a community (Cameron Health Strategies Group, 2009).

This review of planning models suggests workforce capacity building requires attention to factors that address both the supply and demand for occupational therapists. Strategies directed toward workforce supply build service accessibility, while initiatives that address demand consider the appropriate positioning and utilization of occupational therapy services.

Workforce supply considerations

Professional standards: The *Profile of Occupational Therapy Practice in Canada* provides the vision for workforce planning for our profession in our country (CAOT, 2007); it articulates the broad range of roles occupational therapists may assume in their work. This vision outlines tremendous opportunity for occupational therapists. While rooted in the goal of enabling engagement in occupation, the roles, settings and approaches of occupational therapists may vary greatly. To enable diversity, social inclusion and occupational justice, occupational therapists can act in roles such as clinicians, researchers, policy-makers, educators or administrators and work in a broad range of sectors including health, education, community and social services and business. To ensure the capacity of occupational therapists to assume such diverse roles, inclusive standards are required relating to such issues as entry-level education, entry-to-practice requirements and professional development. For example, the practice guideline *Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-being and Justice Through Occupation* articulates characteristics

of occupation-based enablement that address issues relating to any person, environment or occupation (Townsend and Polatajko, 2007).

Workforce size: It is easily understood that the number of occupational therapists in Canada has a direct impact upon the workforce capacity of the profession. While Canada has enjoyed significant growth in the number of practicing occupational therapists in the last decade (CIHI, 2009), a recent report of the World Federation of Occupational Therapists (2010) indicates that the national ratio of occupational therapists per 100,000 population continues to lag behind many countries with similar publicly funded health systems. A direct result is the underdevelopment or withdrawal of occupational therapy services, even in well established practice sectors. For example, Saskatchewan reports the lowest per capita number of occupational therapists (CIHI, 2009) despite the second highest reported provincial rate of disability (Statistics Canada, 2002). As a result occupational therapy practice has migrated away from working with populations with mental health issues in this province. Only 3% of occupational therapists practice with this population in Saskatchewan, compared to the national average of 11% (CIHI, 2009). As accessibility of entry-level education highly influences workforce size, CAOT has worked together with the Saskatchewan Society of Occupational Therapists (SSOT) to lobby for a new education program at the University of Saskatchewan. While this program has received university approval, funding support from the provincial government remains pending.

Canada is a land dependent upon immigration for increased workforce productivity and growth (McIsaac, 2003). With internationally educated occupational therapists (IEOTs) comprising 10% of the Canadian occupational therapy workforce (CIHI, 2009), the ability of the profession to assist occupational therapists educated in other countries with working in Canada represents a significant factor influencing workforce size. Occupational therapy organizations in Canada have undertaken a number of initiatives in partnership with governments and other stakeholders in this area. A current project partners education programs across the country for the Occupational Therapy Entry to Practice and Examination Preparation Program to offer an educational curriculum to assist IEOTs with workforce entry and success (McMaster University & CAOT, 2010).

A significant, frequently overlooked factor influencing workforce size is attrition from the profession. As the age profile of occupational therapists registered to practice in Canada appears to indicate significant attri-

tion after the age of 45 years (CIHI, 2009), concentrated efforts are required to retain the highly valued expertise of experienced practitioners. A recent leadership forum was held in May 2010 with Canadian occupational therapy organizations to explore issues relating to workforce attrition and define strategies to promote continued use of title as an occupational therapist.

Workforce productivity and effectiveness: Along with efforts to increase research and scholarship in occupational therapy, building workforce capacity requires consideration of methods to optimize productivity. Research currently underway to develop a caseload management tool serves as an example of an initiative directed towards improving workforce productivity and sustainability (CAOT, CPA & CASLPA, 2009). Once developed, work will be required to establish benchmarks for caseload allocations for populations with varying needs using the management tool. Recent work to articulate a competency profile for occupational therapy support workers (CAOT, 2008) and the development of accreditation standards for support worker education programs are other examples of efforts to optimize productivity that inform appropriate use of support personnel to enhance the work of occupational therapists.

Workforce demand considerations

Occupational therapy service utilization: We have been fortunate in Canada to have received support from CIHI and Health Canada to work with CAOT and regulators across Canada to build a database of information regarding the supply and utilization of occupational therapists in Canada. This data provides invaluable information regarding how and where occupational therapists provide services in Canada. Comparable data available across jurisdictions and among different professions allows identification of trends and issues that require workforce planning attention. For example, the older age profiles for occupational therapists working in Prince Edward Island and British Columbia indicate the need for leadership for fostering the next generation of occupational therapists in these regions. Our geographical distribution with 95% of occupational therapists working in urban areas requires consideration of supports to better serve rural populations (CIHI, 2009).

Other data sources such as census information can also inform workforce planning. From census data, occupational therapists were identified as the occupational group with the highest rate of interprovincial migration among 25 health professions. Provinces

with the highest rates of in-migration include British Columbia and New Brunswick, where local occupational therapist education programs are not available or are of inadequate size to support the demand for occupational therapy services (CIHI, 2010, CAOT & British Columbia Society of Occupational Therapists, 2007). Initiatives to address these complex issues fall within the mandate of a number of stakeholder groups and require inter-organizational support and collaboration. As an example, the British Columbia Workforce Collaborative was formed in 2009 with representation from professional associations, employers, regulators and government to address human resource planning issues for occupational therapy, including advocating for increased education capacity for occupational therapists in the province.

Population needs assessment: As suggested by workforce planning models, understanding the optimal potential contribution of occupational therapy for the health and well-being of Canadians requires examination of population needs. Review of data such as injury rates and disease prevalence provides insight into areas of practice and approaches where occupational therapists may best have an impact on population health. Acting on this information may require the profession to push from our comfort in well established roles to work in emerging service models and practice areas. For example, epidemiological data indicate the highest rate of injury and death among older adults occurs as a result of falls or in conjunction with driving (Canada Safety Council, 2008; Wilkins & Park, 2004). New interdisciplinary models of primary care delivery in Canada provide opportunities for occupational therapists to work at individual, community and population levels to provide proactive injury prevention programs to address these risk factors. The development of the *Blueprint for Injury Prevention in Older Drivers* (Blueprint) (CAOT, 2009) provides an example of an intersectoral project that examined population needs and defined priorities and strategies to address the issue of older driver safety. Occupational therapists are recognized as leaders in addressing the issues outlined in the Blueprint. Many opportunities to expand occupational therapy research, policy development and service delivery are outlined in the document. The recent publication *Inter-professional Primary Health Care: Assembling the Pieces* (McColl & Dickenson, 2009) provides a step-by-step guide to assist occupational therapists with assessing health needs, determining appropriate service models, roles and funding sources to pursue such opportunities.

Role development: Targeted initiatives can assist the development of the profession where significant gaps in services exist. As an example, a pilot project recently completed in Saskatchewan demonstrated the value of community-based occupational therapy mental health services. By using CIHI data that compared the provision of mental health services across provincial jurisdictions, funding was secured from the provincial government by SSOT and CAOT to conduct a two year pilot program. The outcome data collected from this pilot project is now being used to demonstrate the need for further expansion of occupational therapy mental health services in the province.

The Stable, Able and Strong project serves as a second example of a role development initiative (CAOT & University of Ottawa, 2008). This program was developed to support older adults to resume active living after experiencing a fall and served to demonstrate the role of occupational therapy in this practice area to government funders, clients and other interdisciplinary team members. The program materials and resources are now posted for free download on the CAOT website to promote occupational therapy practice in the area of fall prevention and post fall support.

Representation and advocacy: A key factor in creating a successful occupational therapy workforce is having a strong and effective voice at the table when decisions are made regarding program service development, role delineation and funding allocations. Such decisions are usually not made quickly or without consultation. Occupational therapists need to be an active and valued partner in the consultation process by volunteering time to sit on committees, providing feedback, writing documents, chairing task forces, meeting key stakeholders and speaking out on issues that are important for our mandate in enabling occupation. Opportunities exist to participate at the organizational, regional, provincial, national and international level and occupational therapists have an important contribution to provide that is not represented by other parties; we need to ensure we provide our voice to the issue. For example, in the fall of 2010 CAOT will be presenting to the federal Finance Committee to advocate for strategies and tax credits that reduce barriers to participation and promote active living. Occupational therapy is not a profession well known to the public in Canada but it is through efforts of occupational therapists working with our communities that a stronger voice can be heard for enabling health, well-being and justice through occupation.

Summary

Effective workforce capacity building requires a coordinated strategy that addresses a multitude of factors. While helpful, single initiatives such as increasing entry-level education programs are not sufficient to effectively build workforce capacity. This coordinated effort requires collaboration and vision among many stakeholders, particularly occupational therapy organizations and leaders. As a small profession, we cannot afford to waste efforts on duplicating services or inter-organizational politics that fracture our approach. Occupational therapists need to ensure our efforts are coordinated, strategic and targeted to best meet the needs of the Canadian population.

Acknowledgements

The author would like to thank Elizabeth Townsend who provided input for the development of this paper.

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Monthly donor profile: Donna Campbell

Donna Campbell is a Past CAOT President and was actively involved with CAOT when COTF was established, providing her a clear understanding of COTF's purpose. In the beginning, there was very little support for research and scholarship in occupational therapy, but Donna understood the importance of improving the profession's involvement in both. In fact, Donna was personally motivated to improve her own academic credentials and to promote the integration of research and scholarship in her workplace. In Donna's own words, 'Walk the talk in your own life. Because I can't do it all by myself, I like to support those who can move

forward further and faster than I can.' Donna credits her husband as being a strong model in terms of charitable giving. Thus, she feels a sense of obligation to support causes that improve society in some way. Donna supports a variety of causes in a balanced way. She shares that 'being a monthly donor allows me to give more significant amounts overall while planning and managing my cash flow. It's easy to do on-line and allows the causes I support to plan. I also appreciate the tax implications of making charitable donations.' Now retired, Donna still believes in COTF and continues to support the Foundation on a monthly basis. She has been doing so since October, 2003. Thank you, Donna!

To become a COTF monthly donor like Donna, please visit www.cotfcanada.org or www.canadahelps.org. Donating \$5 per month is the equivalent of approximately two to three coffees at your favourite coffee shop. Monthly donations benefit COTF by providing a regular income for the important awards programs that COTF offers to occupational therapists. We encourage you to sign up. Thank you to all of the other monthly donors for being so generous on a monthly basis.... it is greatly appreciated!

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Pediatric Home Modification Recommendations: Assessing Environments and Future Needs

Presenter: Tanya Eimantas
Time: Tuesday, 12:00 to 1:00 pm (EST)
Date: November 16, 2010
Cost: \$50 for CAOT member/\$75 for non-member | Register by: November 9, 2010

Seeing our Clients through their Journey with Vision Loss: What Occupational Therapists can do for Clients of all Ages with Low Vision

Co-Presenters: Lara Anderson and Corie Haslbeck
Time: Tuesday, 12:00 to 1:00pm (EST)
Date: November 30, 2010
Cost: \$50 for CAOT member/\$75 for non-member | Register by: November 23, 2010

Integrating Rehabilitation Principles into Chronic Disease Self-Management

Presenter: Lori Letts
Time: Tuesday, 12:00 - 1:00 pm (EST)
Date: December 14, 2010
Cost: \$50 for CAOT member/\$75 for non-member | Register by: December 7, 2010

CAOT Water Cooler Talks:

CAOT on Parliament Hill

Presenter: Liz Taylor, CAOT President
Date: Thursday, November 25th, 2010
Time: 12:00-1:00pm (EST)

CAOT Endorsed Courses:

The DIR® Approach to Pediatric Feeding

November 8 & 9, 2010 in Pasadena, CA and March 28 & 29, 2011 in Las Vegas, NV

This two day, intermediate level course will present an interdisciplinary perspective to pediatric feeding challenges incorporating the DIR®/Floortime™ approach. The multiple components of feeding will be addressed and integrated into a broader relationship-based approach to assessment and treatment. Our speakers will provide comprehensive strategies for addressing feeding concerns across a variety of diagnoses with an emphasis on the importance of the parent-child dyad. Video case studies will be used to illustrate practical solutions to complex feeding disorders.
Speakers: Diane Cullinane, MD, Karla Ausderau, PhD, OTR/L, SWC, and Patricia Novak, MPH, RD, CLE.
Contact: Barb Bobier: barb@pasadenachilddevelopment.org or visit the website: www.pasadenachilddevelopment.org.

2nd Conference on Positive Aging: An Interdisciplinary Approach for Health Professionals

November 26 & 27, 2010
Vancouver, BC

The aim of the 2nd national conference on positive aging is to bring together an interdisciplinary audience of health professionals and researchers to address some of the issues and challenges facing the aging population today. Hear about the most current research findings from leading experts, learn

how research can be translated into practice, and discover useable resources to promote healthier, more positive living for Canada's older adult population. The importance of purpose and meaning of the later life as well as lessons for health and longevity will be emphasized. The conference will provide informative lectures, discussions, workshops, poster sessions and ample networking opportunities. A highlight of this conference will be to hear from the Older Adults.

For more information: http://www.interprofessional.ubc.ca/Positive_Aging_2010.html or contact 604-822-7524 or via email ipad@interchange.ubc.ca. Please indicate the name of the conference in the subject of your email.

The Coast Plaza Hotel & Suites
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Vancouver, BC

Feeding the Whole Child: A Mealtime Approach Conference at Sea

A 5 night cruise to Grand Cayman and Cozumel, Mexico
Aboard the Carnival "INSPIRATION"
departing Tampa, Florida
March 26 – 31, 2011

Please join us for the first of its kind conference-at-sea on Dysphagia, presented by Suzanne Evans Morris, PhD. This workshop will explore some of the road blocks that limit the development of eating skills and comfort to help children return to their natural desire to be part of mealtimes. Strategies designed to increase feeding skills within the mealtime environment are discussed, for children who eat/drink

by mouth and for those on feeding tubes.

Contact: Helga Schollenberger, Rehab Department
Windsor Essex County Pediatric Feeding & Dysphagia Group
c/o Hotel Dieu-Grace Hospital, 1030 Ouellette Ave., Windsor, ON.
Tel.: (519) 973-4411
Email: hschollenberger@hdgh.org

Sensory Processing Disorder: Subtypes, Intervention and Evidence-Based Research

May 5th-6th, 2011
Montreal, Quebec

This is a comprehensive 2 day seminar that will focus on sensory processing disorder (SPD). SPD affects at least 16% of children. This seminar will review screening and assessment of SPD as well as intervention for the types of SPD.

Contact: Caroline Hui, OT
Tel.: (450) 242-2816
Email: info@choosetolearn.ca
For more information, please visit www.choosetolearn.ca/pdf/Sensory_Processing_Disorder.pdf

TLP Provider Certification Course

September 23rd- 25th, 2010 and
November 11th – 13th, 2010
Ogden, Utah, USA

This is a comprehensive three-day course. You will leave with the information you need to immediately apply The Listening Program® method and individualize listening plans to meet specific client needs and goals. This all-inclusive course will prepare you to use all TLP listening systems with your clients including the ABT Bone Conduction System. An optional online review course is included as part of your training.
September 23rd- 25th, 2010

November 11th-13th, 2010
The online course provides instruction to prepare you to offer ABT programs to your clients including The Listening Program® and ABT Bone Conduction System.
Contact: Mandy Doman, Events Manager, Advanced Brain Technologies
Tel.: 801-622-5676
Email: mandyd@advancebrain.com